

The Mismanagement of Hypertension

In this issue of the ARCHIVES (p 1707), Alderman and Ochs document major deficiencies found in the long-term management of hypertensive patients treated in the outpatient department of a large teaching hospital. In reviewing the records of the clinic, they found that half of the hypertensive patients were unavailable for follow-up within six months of the initial visit. Of those who remained, less than 25% achieved a reduction of blood pressure to below 160/95 mm Hg. Furthermore, publication of controlled clinical trials demonstrating conclusively the effectiveness of drug treatment in hypertension failed to have any impact on the already unsatisfactory management of the clinic patients.

See also p 1707.

Finnerty et al¹ attempted to uncover the reasons for the large number of dropouts from their teaching clinic. Their method was to question the patients who had dropped out. The patients complained that they were treated like second-class citizens. They said they waited three hours to see a strange doctor for five minutes who knew nothing of their case history and then waited two more hours to have their prescriptions filled. To correct the problem, Finnerty and colleagues replaced the rotating house-staff physicians with nurse specialists and trained nurse assistants. Each patient was assigned to a given nurse or nurse assistant who always saw that patient. To eliminate waiting time, patients were seen by appointment and medications were prepackaged the day before the clinic visit. A physician served as overall supervisor and consultant. As a result of the prompt and personalized atten-

tion, there was a dramatic decrease in the rate of dropouts and a comparable increase in compliance.

Apparently, many patients can be taught to comply, but for some to continue to comply, there is need for constant reinforcement. For example, Wilber and Barrow² greatly increased compliance by employing nurses to make home visits. Once the program was dropped, however, most of the patients reverted to their former habits. McKenney, a pharmacist, and his co-workers³ interviewed patients during each of their clinic visits, providing them with general information on hypertension and specific details on each of their medications. They questioned the patients on compliance and sought out side effects. When indicated, they recommended changes to the attending physician. Compliance increased from 25% to 79% during the interview program, but after the program was dropped compliance fell to 42%.

Too often our best efforts to gain compliance go for naught in asymptomatic hypertensive patients. Such patients often remain unimpressed with the seriousness of their condition. Sackett et al,⁴ for example, were unable to improve compliance in a group of industrial workers despite an elaborate teaching program that included quizzes to make certain that the information was learned. In fact, according to Sackett et al, the only intervention that significantly improved compliance under controlled conditions was the use of blood pressure recordings in the home. I have used this technique for many years⁵ and have similarly found it to be a useful way to increase compliance.

It is evident that a university hospital clinic operating in a traditional manner can no longer be

regarded as an acceptable modality for delivering prevention treatment in hypertension. And yet, it is not desirable in a teaching institution to exclude the student or physician in training from gaining experience in the long-term management of hypertension. We have attempted to meet this problem in our hypertension clinic by allowing the nurse specialists to take over the primary care of the patients with uncomplicated hypertension. However, the house-staff physicians are available on call to handle any unusual problems that may arise. In addition, those patients with complicated problems are seen primarily by house-staff physicians. Such patients also are seen by the nurse specialists, who conduct interviews with respect to side effects, compliance, and other problems. In addition, the nurse specialists maintain an ongoing program of education in the need for continuing treatment, and serve as contacts to whom the patient can relate over a long period of time. A satellite pharmacy is provided so that patients will not be required to wait for their drugs.

If improvements are to be made, the first step is to recognize that the traditional hypertension clinic is inadequate to provide effective long-term treatment. Hopefully, such recognition will then be followed by changes designed to cope with the most important and most difficult problem in long-term care, the motivation of the patients to continue treatment for an indefinite period of time.

EDWARD D. FREIS, MD
Washington, DC

References

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